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CHAPTER EIGHT

WOMEN SURVIVORS OF ABUSE AND DEVELOPMENTAL TRAUMA

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There is a small but growing practice of music therapy with women survivors of violence, first identified and described in 1990 by Cassity and Theobod and gradually growing since then (Austin, 2006; Curtis, 2000, 2006, 2007, & 2008; Curtis & Harrison, 2006; Day, Baker, & Darlington, 2009; Fesler, 2007; Gonsalves, 2007; Hahna & Borling, 2004; Hammel-Gormley, 1995; Hernánadez-Ruiz, 2005; Lasswell, 2001; MacIntosh, 2003; Montello, 1999; Rinkler, 1991; Rogers, 1993 & 1994; Slotoroo, 1994; Teague, Hahna, & McKinney, 2006; Ventre, 1994; Whipple & Lindsey, 1999; York, 2006). This has accompanied an increasing awareness overall of the serious extent and nature of violence against women. In the United States, during their lifetime, one in four women will experience domestic violence and one in five women will be raped, with 1.3 million women raped every year and an average of three women per day killed by their intimate partners (Black et al., 2011; Kanani, 2012). Furthermore, an estimated 12 to 38% of American women have experienced childhood abuse (Schacter, Stalker, & Teram, 2001). Yet it is difficult to accurately document the full prevalence of violence against women because of underreporting and undercounting (Curtis, 2006; Hahna & Borling, 2004; Kanani, 2012). These are hidden crimes with many reluctant to report because of the personal nature of the violence and for reasons of fear and shame. With gender frequently neglected in reporting processes, the challenge to fully capture the incidence rate is further exacerbated.

While violence against women has been ignored or overlooked until recently, there is now a growing recognition that it is pervasive, persistent, and incredibly detrimental. This recognition includes an understanding of the broader scope of the costs of such violence—the personal costs (both short-term and long-term) and the societal costs in terms of public health, criminal justice, and the economy (Curtis, 2008; Kanani, 2012; Statistics Canada, 2006). At the societal level, economic costs alone for women, children, and communities run in the billions of dollars annually. These include medical and mental health care costs, law and legal services costs, shelter and foster care costs, property loss, and work place costs such as productivity loss (Teague, Hahna, & McKinney, 2006). At the personal level, the cost is immeasurable (Curtis, 2007; Kanani, 2012). Ultimately, it damages the very fabric of social justice. In the estimation of Susan Carbon, Director of the U.S. Department of Justice Office of Violence against Women:

I view violence against women, in all its forms, as a fundamental human rights issue. And whether it is used as a weapon of war against an entire people, or to break one individual's spirit, we all know its impact is profound: it usurps victims of their right to sovereignty over their own person (Kanani, 2012).

Regardless of the incidence rate, even one woman harmed by such violence is one woman too many (Curtis, 2000).

Given the large numbers of women experiencing violence, both in their adulthood and in their childhood, and given their understandable reluctance to reveal these experiences, one thing is certain. Music therapists can expect to see among their clients a number who have been touched by violence against women (Curtis, 2007). And these clients are “deserving of the best we can offer them, an approach informed by the latest understanding of violence against women and children . . . and of effective intervention strategies” (Curtis, 2007, p. 199).

While the topic of this chapter is clearly identified as and limited to women survivors of abuse and developmental trauma, the question may arise for some readers concerning the exclusion of male survivors. This exclusion was purposeful and based on compelling reasons. Male violence against women has unique parameters and dynamics in our sociocultural context. It is rooted in a patriarchal culture which has historically accepted and condoned such violence. Typically, women’s experiences of violence are very different than those of men. Women are more likely to experience violence in their own homes at the hands of a significant other, with greater risk of sexual abuse; (Curtis, 2008; Kanani, 2002; Statistics Canada, 2006); men’s experiences of violence are more often outside their homes at the hands of strangers.

Male violence against women cannot be completely understood without an examination of the dimensions of gender and power, or without an understanding of the historical and current sociopolitical underpinnings within our sociocultural context. It is rooted in a culture of inequality. As such, it requires not only a sociopolitical understanding, but also a sociopolitical solution (Curtis, 2000, 2007, 2008; Worell & Remer 2003; Yllö & Bograd, 1988).

Gender-based violence is perhaps the most widespread and socially tolerated of human rights violations. It both reflects and reinforces inequities between men and women and compromises the health, dignity, security, and autonomy of its victims (Statistics Canada, 2006, p. 8).

Men do experience violence within adult relationships; however their experiences are unique as are the impact and the sociocultural response. In the case of child abuse, boys are affected as well as girls and this is rooted in patriarchal culture. As such, men’s and boys’ experiences should not be underestimated. It plays out, however, quite differently because of their particular gender role socialization in a patriarchal culture. It can also play out differently in the case of same-sex child abuse within the context of a homophobic culture. It is important therefore that separate time and attention be given to the unique experiences of abused men and boys in order to provide unique guidelines for appropriate and sensitive practice in this area.

For similar reasons, violence against women within same-sex relationships is not examined in this chapter. The dimensions of gender and power are very different in a culture which is both patriarchal and homophobic. As such, separate time and attention to this unique experience is also needed in order to provide unique guidelines for appropriate and sensitive practice here as well.

Having identified and examined the scope of this chapter, only one thing remains prior to proceeding—to identify what Brown (2008) refers to as multiple social locations. These personal identities and experiences form the lenses of each person's particular worldview. Disclosure of these social locations is critical, particularly given the identified sociocultural dimensions of work with women survivors of violence. My own social locations include my experiences as a White, middle class, educated, able-bodied, heterosexual woman born in the mid-1950s. Furthermore, over the past years, my work has included social activism, anti-oppression work, and feminist music therapy practice. It is the combination of these social locations which provide the framework for my practice, research, and writing.

In this chapter I will look at the full scope of practice of music therapy with women survivors of abuse and developmental trauma, grounded in work of those from a broad array of social locations. Attention will focus first on pertinent diagnostic information as well as on identifying the needs and resources of women who have experienced violence. The diversity of women and of their experiences of violence will then be examined in the area of multicultural issues. The importance of social locations will be further highlighted here, with attention to their complex interaction with both clients and therapists. A detailed and comprehensive overview of music therapy practices will follow, providing guidelines for receptive music therapy, improvisational music therapy, compositional music therapy, and re-creative music therapy for use with women survivors of violence. The chapter will conclude with a look at efficacy research supporting and informing this emergent area of music therapy practice.

Diagnostic Information

Diagnostic information in this emergent area is still at a preliminary stage, with existing controversies concerning not only diagnosis and diagnostic criteria, but also whether or not a diagnosis should be made at all (Curtis, 2000, 2007, & 2008; Brown, 2008; Burstow, 2005). This is perhaps not surprising given the newness of the field and given the longstanding contention surrounding the naming of the very phenomenon of violence against women. The power of naming (and diagnosing) should not be underestimated. It can reflect and perpetuate understandings or misunderstandings; it can acknowledge a phenomenon or deny existence of that which is not named.

Until fairly recently, there was no name for the phenomenon of violence against women within their intimate relationships. Initially viewed as a husband's right, then challenged and identified as a problem during the second wave of the women's movement, it was subsequently given an assortment of names—from wife abuse, spousal abuse, and marital conflict to domestic violence. Many of these masked the dimensions of gender and power, and moved the dialogue from political to personal. Lenore Walker's concept of Battered Woman Syndrome (BWS) gained widespread acceptance for a time and appeared to address some of these issues. Ultimately, however, it posed its own set of problems in pathologizing women, not accurately capturing women's experiences of violence, and not serving adequately as the hoped-for legal defense (Curtis, 2000).

Current attempts to address these problems have seen rise of the use of the concepts of Posttraumatic Stress Disorder (PTSD) or Trauma with adult women

experiencing male violence (APA, 2000; Brown, 2008). PTSD—a diagnostic category of the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual (DSM)—is one of the few categories by and large established and accepted by non-psychiatrists; its impetus was to validate the experience of trauma, to acknowledge its effects, and to provide access to services (APA, 2000; Burstow, 2003). Applied to adults, adolescents, and children older than 6 years (with a separate Pre-School subtype for younger children), PTSD is identified in the DSM V Development under Criterion A as “exposure to actual or threatened a) death, b) serious injury, or c) sexual violation” (APA, 2012, DSM V Development. “Posttraumatic Stress Disorder,” para. 1); Criteria B, C, D, and E identify associated clusters of symptoms or disturbances including: intrusive, distressing memories and dreams, dissociative reactions, psychological distress, physiological reactions to trauma reminders, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity associated with the traumatic event (APA, 2012).

The use of the PTSD diagnosis with women who have experienced male violence has been criticized, with considerable efforts put into its revision for the 2013 edition of the DSM V (APA, 2012; Brown, 2008; Burstow, 2005). Burstow (2005), however, contends that no revisions would be adequate, that the PTSD diagnostic category is fundamentally neither valid nor redeemable. She challenges it as being reductionistic, contradictory, inaccurate, and incomplete, serving to pathologize purposeful coping strategies. In medicalizing trauma, it ignores the context of the individual, the trauma, and the response; it further neglects the particular context for those who belong to oppressed groups. “PTSD is a grab bag of contextless symptoms, divorced from the complexities of people’s lives and the social structures that give rise to them. As such, the diagnosis individualizes social problems and pathologizes traumatized people.” (Burstow, 2003, p. 1296). Furthermore, the diagnosis (with its use of the term *post*) does not accurately capture the ongoing nature of this type of violence. Burstow (2003) contends that while the concept of PTSD is flawed, there are some compelling reasons to continue with the use of the term Trauma (viewed not as a diagnosis, but as a reaction): it is a term used by traumatized people themselves, and not part of professionalized psychiatric language; it captures the overpowering nature of the experience; and as “contested terrain” (Burstow, p. 1294), it contains potential for its meaning to be transformed to include the sociopolitical context. It also, however, continues to mask the dimensions of gender and power, as well as the connection between the various types of male violence against women (Curtis, 2000; Curtis, 2008).

Similar difficulties have been identified with diagnoses surrounding childhood abuse. Additionally, they neglected the unique nature of this violence and its impact at a child’s critical developmental age (Van der Kolk et al., 2009). Attempts to address this can be seen in proposals for a new Developmental Trauma Disorder diagnosis and for inclusion in the DSM V within the PTSD category of a Pre-school Subtype for children age 6 and younger (Van der Kolk et al.; APA, 2012). Across the board, however, with all of these changes, what remains is that the dimensions of gender and power continue to be masked, as does the connection between all types of violence against women and children (Curtis, 2000, 2006, 2007, & 2008).

Woman abuse is an alternative term supported by many to address these issues (Curtis, 2000, 2006, 2007, & 2008; Worell & Remer, 2003). It is “the preferred term to

identify all forms of male violence against women” (Curtis, 2007, p. 204), with the purpose of each type being to assert and maintain control. “It is a pattern of coercive control over women that uses diverse methods and leaves women questioning their self-worth and perception of reality” (Yllö & Bograd, 1988, p. 14). The various types of violence can occur at any time throughout a woman’s life span and may include: physical, verbal, sexual, psychological, and systemic violence, the latter resulting from the failure of legal, social, and mental healthcare services agencies to respond or to respond appropriately (United States Department of Justice, 2012; Statistics Canada, 2006; Curtis, 2000).

Music therapists need to be familiar with these issues surrounding women survivors of violence, the information provided on one hand and the challenges faced on the other with diagnosing or naming. They will also be better prepared in having an understanding that many of their clients may arrive without diagnosis or any previous indication of experiences of violence.

Needs and Resources

In light of this understanding of the complexities surrounding violence against women, the section which follows will examine women’s experiences in terms of their responses exemplifying both strengths and challenges, both resources and needs. Women, women’s experiences, women’s experiences of violence, and the meanings women make of these experiences are incredibly diverse. This diversity will be explored not as symptoms of a disorder, nor as causes of the violence, but as characteristics resulting from women’s experiences of extraordinary trauma. It is important that women be neither pathologized nor blamed for the violence; nor should they be defined by it (Curtis, 2008). While there is no doubt they have been victimized, they are survivors, rather than simply victims, of violence. Their diverse responses reflect resourceful coping strategies, great strength, and remarkable resilience. As such, they may differ in what time and help they may need to heal, and this will depend on: the nature of the violence, the available resources (personal, social, and societal), the coping skills, the presence of children, and the intersection of any other sources of oppression (Curtis, 2008). These and other issues of diversity will be examined more fully later in this chapter in the *Multicultural Issues* section. What follows immediately is an identification of the full scope of possible responses and characteristics—short-term and long-term; physical, emotional, psychological, and behavioral—as described in trauma work literature and in the DMS-5 Development (APA, 2012; Amir, 2004; Austin, 2006; Burstow, 2003; Curtis, 2006, 2007, 2008; Care, 2006; MacIntosh, 2003; Montello, 1991).

Women survivors of violence can experience profound and persistent long-term as well as short-term effects. With betrayal and coercive control underpinning all types of this violence, the impact may often be hidden, unidentified, or unacknowledged. For some survivors of childhood abuse, it may only be as adults that the experience is revealed. For many, the impact can be reflected in their adult health, with increased risk of depression, suicidal tendencies, substance abuse, smoking, obesity, and sexual problems (Van der Kolk, 2005). For all, the damage to the core self is identified as one of the most significant and long-lasting harms, the most difficult to overcome (Curtis & Harrison, 2006).

The DSM V Development (APA, 2012) identifies and organizes the possible scope of responses in the areas of intrusion, avoidance, negative cognitive or mood alterations, and arousal or reactivity alterations. These responses may include: intrusive distressing memories or dreams; dissociative reactions such as flashbacks; intense psychological distress; physiological reactions to reminders of the trauma; avoidance of external reminders of the trauma; avoidance of internal reminders in terms of thoughts or feelings; negative beliefs or expectations about themselves, others, or the world; distorted self-blame; negative emotional states such as fear, horror, anger, guilt, or shame; diminished involvement in activities; numbing; detachment; irritable or aggressive behavior; reckless or self-destructive behavior; hypervigilance; and sleep disturbances. The responses can present in oppositional fashion: intrusion versus numbing, hypervigilance versus denial, flooding versus constriction (Burstow, 2003; Montello, 1999).

Burstow (2003) encourages an understanding of women's responses as including effective coping strategies under the circumstances. Furthermore she urges caution in assessing survivors' fears as exaggerated, noting that their view of the world as unsafe might be closer to reality than not. Ultimately, the critical role of context cannot be ignored. The violence takes place within what was a loving, trusted relationship (Austin, 2006; Van der Kolk, 2005). The violence also takes place within a larger sociopolitical context. Burstow (2003) describes women's responses with an understanding of the many layers of trauma: individual response, response of other individuals, response of the community, and response of institutions.

In examining the responses of women survivors of violence, their strengths should not be overlooked. Rather than helpless, they actively seek help—although institutional response may not itself be helpful. Abused women develop many effective survival skills, making use of coping strategies, some of which serve them well at the time. They also demonstrate an understanding of others who have been traumatized, along with a strong commitment to social justice and much-needed activism (Burstow, 2003; Curtis, 2008; Curtis & Harrison, 2006).

Just as abused women's responses and strengths are reflective of great diversity, so too are their music interests and abilities. Abused women come from all walks of life; they are represented in all ethnic identities, in all socioeconomic classes, and among people of all abilities. As a result, little specific concerning music can be said about abused women as a whole. Music therapists working in this area can be guided by an understanding of the importance of individual preference. Furthermore, there is an enriching opportunity which comes from supporting clients in sharing the wealth of their expertise—expertise in their music, as well as their culture, their experiences, and the meaning they make of these. Additionally, as will be explored later in this chapter in the *Guidelines* section, some music therapy methods in this area of practice include the use of women's music. Equally as diverse as the practice itself, women's music can be defined as “music written by, for, and about women which began as a recognizable genre during the women's movement of the 1970's and continues today as a source of empowerment and social change” (Sallie Bingham Center for Women's History and Culture, 2012, para. 1).

Multicultural Issues

Given the diversity of abused women and their experiences of violence, attention to multicultural issues is critical. While important in any area of music therapy practice, the need is underscored in work with abused women not only by their diversity, but also by the clearly-identified, powerful sociopolitical underpinnings of violence against women. In this section of the chapter, multicultural issues will be carefully examined. The scope of this examination will move beyond a look at music and the meaning of music in a particular culture, the look primarily taken until recently in music therapy. This examination will encompass multicultural issues as they play out in the lives of abused women, in their interactions in the client-therapist relationship, and in the lives of therapists as well.

Until recently, it was easier for healthcare professionals (including music therapists) to see themselves as neutral, caring individuals (Brown, 2008). There is now, however, an increasing understanding of the myth of this neutrality, an understanding of the complex influence of multiple identities in the lives of everyone—client and therapist alike. Brown conceptualizes this diversity in terms of social locations—“a variety of different experiences that can affect identity. Some can have a biological portion; all are socially constructed to a degree” (Brown, 2008, p. 21). These multiple and intersecting social locations include: Age, disability, religion, ethnicity, social class, sexual orientation, indigenous heritage, national origin, and gender/sex, as well as vocation, body size, health, experiences of colonization, and choices concerning partnering and parenting. These can be sources of privilege or oppression, with most people experiencing some combination of both. Privilege arises from the unearned advantages that come with dominant group membership, while oppression is “a pervasive pattern of prejudice and discrimination at the individual and systemic levels, resulting in personal and societal barriers and power differentials” (Curtis, 2007, p. 204). Additionally, oppression can be internalized, with the oppressed coming to believe they are deserving recipients of discrimination.

For therapists, in addition to any personal experiences of privilege or oppression, they are privileged by virtue of their professional training and the power differential in the client-therapist relationship. For clients, there is the additional complex interaction of the trauma itself: “Trauma and its psychic aftereffects have a texture. The experience conveys meanings that derive from personal histories; cultural heritages; and the social, political, and spiritual contexts in which the painful event happens” (Brown, 2008, p. 3). Even with such a seemingly neutral trauma as a hurricane, the complex interaction of diversity, privilege, and oppression became quickly and powerfully evident in New Orleans with Hurricane Katrina. With violence against women, deeply rooted as it is in the sociopolitical context, the interaction is undeniable.

In light of this, how are music therapists to prepare themselves to provide the best possible practice with women survivors of violence? It requires a thoughtful and self-reflective process. While some efforts have been focused on acquiring cultural competence, others recommend cultural humility (Brown, 2008; Juarez et al., 2005; Schacter et al, 2009; Tervalon & Murray-García, 1998). With a focus on both attitude and skill development, cultural humility is defined as “a process that requires humility as individuals continually engage in self-reflection and self-critique as life-long learners and reflective practitioners” (Juarez et al., 2005, p. 118). With the best of both in a culturally-

sensitive practice, therapists examine their own multiple social locations and related attitudes and beliefs. Within their practice and as part of an ongoing process, they take three stances: an alliance stance, an ignorance stance, and a respectful stance (Brown, 2008; Tervalon & Murray-García, 1998). Within an alliance stance, the therapist acts as ally and advocate, recognizing the client's own skills and efforts in problem solving. The ignorance stance is an acknowledgement of the therapist's limitations, but openness to learn. A therapist takes a respectful stance in honoring the client's perspective and in recognizing the diversity of human experience. These three stances can be taken in relation to the client in general terms as well as to the clients' music, their understanding of the role of music in their culture, and their understanding of the role of music in healing.

Having looked at the preparation needed by music therapists in terms of diagnostic information, client characteristics, and multicultural issues, specific guidelines for clinical practice with abused women will be presented in the section which follows. While the methods may vary, one constant is the need for therapist attention to the possibility of vicarious trauma. Vicarious trauma is the trauma that may be experienced by therapists while their clients relive and retell their stories of trauma (Burstow, 2008). Music therapists can continue to provide an effective music therapy practice in this area with careful attention to self-care, supervision, and any necessary support.

Overview of Methods and Procedures

What follows are guidelines for a variety of receptive music therapy methods. The application of these methods, as with those for improvisational, re-creative, and compositional methods, has been seen within individual settings, group settings, or some combination. Some working in this area highlight the importance of group therapy, which can be particularly effective in the critical work of breaking the social isolation in which women are placed by their abusers (Curtis, 2000, 2006 & 2008; Teague, Hahna, & McKinney, 2006; Whipple & Lindsey, 1999). It should also be noted that the particular application of these methods can be varied, with a combination of several methods used in a single session, while conversely a single method may be spread across several sessions. Each session is generally 90 minutes to 1 hour in duration and held once or twice weekly. The following methods and procedures are used most commonly with women survivors of abuse and developmental trauma

Receptive Music Therapy

- Music-Centered Relaxation: includes a variety of exercises including breathing, progressive muscle relaxation (PMR), and guided imagery.
- Lyric Analysis: the client chooses songs, listens to a recording and/or sings them with the therapist, and discusses the themes which arise.
- Bonny Method Guided Imagery and Music (BMGIM): involves the client (traveller) listening to classical music programs in an altered state while dialoguing with the therapist (guide) about the images and sensations that are evoked.

Improvisational Music Therapy

- Group Music Improvisation: involves creating music extemporaneously in a group with the voice or instruments with or without a theme.
- Individual Music Improvisation: involves creating music alone or with the therapist extemporaneously using voice or instruments with or without a theme.

Re-creative Music Therapy

- Reflective Singing: clients are engaged in singing with the therapist along with the original recording of a song.
- Performance: clients select pieces, practice them, and perform them for an audience.

Compositional Music Therapy

- Song Writing and Recording: clients work individually or in a group to write a song on a therapeutic theme, then perform and record it to listen to themselves sing it.

Guidelines for Receptive Music Therapy

Music-Centered Relaxation

Overview. Music-Centered Relaxation can include a variety of exercises including breathing, progressive muscle relaxation (PMR), and guided imagery. Typically abused women, whether their experience of abuse is recent or longstanding, can benefit from support in increasing their relaxation. Caution is advised to first ensure that a safe place has been successfully established for the client in therapy, prior to undertaking this method. The goals of this method are to increase relaxation and effective use of relaxation skills, including independent stress management skills by the client outside of therapy. Additionally, within a framework of Feminist Music Therapy, Music-Centered Relaxation is used as part of feminist analysis of gender-role socialization with a goal of increasing understanding of women's need for self-nurturance (Curtis 2000). The level of therapy involved is augmentative or intensive. While no specialized training is needed to use this method, previous experience in stress management would be beneficial.

Preparation. The location used for this method should be a quiet, private space which is conducive to relaxation—comfortable seating, appropriate lighting which can be dimmed as needed, and a door which can be closed to minimize outside distractions. The therapist can use live or recorded music. In the case of recorded music, a good selection of diverse music choices appropriate for relaxation should be on hand; instrumental music is recommended so as not to distract from the verbal relaxation guidance provided.

Music selections and playlists prepared in advance on an iPod or iPad can be very useful, with CDs as an alternate option. The therapist may also wish to have relaxation CDs with recorded relaxation scripts on hand for clients to borrow for independent use between sessions. The relaxation script used by the therapist in session or on CD can be individualized; samples of such scripts and exercises are available commercially and online (Davis, Eschelman, & MacKay, 2000)

What to Observe. The therapist can attend to client response—verbal and nonverbal, including breathing rate, body position, and muscle tension. Pre- and post-session discussions can provide additional information. The therapist may also opt to have clients complete pencil and paper pre- and post-session relaxation self-ratings on simple Visual Analog Scales (VAS) or 5-point Likert Scales; clients may also use these to track their own progress in relaxation work between therapy sessions.

Procedures. The Music-Centered Relaxation method starts with a brief discussion; this allows the therapist to share some information about stress management and the method being used and it allows the client to check in. In Feminist Music Therapy, this discussion includes feminist analysis of gender-role socialization, which may be completed with additional, preliminary use of Lyric Analysis based on the theme of self-nurturance (See the section which follows for more details on this).

Following any preliminary discussion, the therapist moves into the music-centered relaxation experience. Clients are directed to get into a comfortable position (they may be seated if comfortable chairs/sofas are available or they may lie stretched out if yoga mats are available). Clients may close their eyes or, for those more anxious, look at a blank spot in the room that offers no distractions. In guiding clients through this experience, it is helpful for the therapist to think of *giving permission*, rather than *giving directions*. For example, use of phrases such as “allow yourself to focus on your breathing”, or “you might imagine a warm relaxing sensation moving through your muscles”. The therapist can enhance the experience by reflecting a sense of relaxation in the tone, pitch, and pacing of her voice.

With the clients seated comfortably and the music started, the therapist can guide them through a short induction where they focus on the music and their breathing, gradually slowing their breathing as they match it to the music’s tempo. If live music is being used, the therapist can move from a faster, more dynamic style, to a slower, more static one. The therapist can then guide the clients through a music-centered PMR experience. Music-centered PMR involves alternately tensing and relaxing muscle groups throughout the body in a systematic process. Grounded in a very physical response, it can be helpful for those at the beginning stages of the therapeutic relationship, where guided imagery might be too threatening. The therapist can guide clients through this process, starting with the feet and gradually moving upward through the body to the head. Time can be allowed for the client to feel the opposing sensations of tension and relaxation; time can also be allowed to re-direct focus to the breathing and to the music. Allowing opportunity for the music to play alone without any verbal guidance can also be beneficial. The therapist may end the experience here, or may follow it with an extended music-centered guided imagery. If choosing to end the experience with PMR, the therapist then guides the client’s attention back the feel of the body, its place and position in the room, its feeling of relaxation, and then back to the sounds of the room, as each client becomes more aware of their surroundings. The

session can wrap up in verbally processing the experience and its meaning for the moment and for the future.

Adaptations. Music-Centered Guided Imagery is another receptive method; it may be used alone or in some combination with Music-Centered PMR (before or after). In this method, the therapist guides the client through a relaxing scenario. While the term imagery is used, this involves a focus on all of the senses, not just the visual. In working with an individual client, the client can provide input for the scenario to be described; in working with a group, this may have to be negotiated. Alternately, the therapist can guide the group, using broad descriptions which allow each client to fill in the blanks. For example, they may be guided to imagine themselves in a familiar, relaxing place. As with Music-Centered PMR, this method closes with an opportunity for verbally processing the experience.

Lyric Analysis

Overview. In lyric analysis, the client chooses songs, listens to a recording and/or sings them with the therapist, and discusses the themes which arise. Lyric Analysis has been shown to be an effective music therapy method used across diverse approaches with abused women (Cassity, & Theobald, 1990; Curtis, 2000, 2006, & 2008; Curtis & Harrison, 2006; Whipple & Lindsey, 1999; Teague, Hahna, & McKinney, 2006; York, 2006). It can be particularly effective in a group therapy setting where each woman can contribute at the level they are able. There are generally no contraindications for clients if the experience is handled by the therapist in a skilled and sensitive manner. The goals of this method are varied and can include allowing opportunities: to explore issues related to violence against women, first at the impersonal level of the songwriter, and later at the personal level of the client; to break the social isolation in hearing other women's stories of abuse (the songwriter's and other clients'); to give voice to woman clients long silenced; to validate women's experience of abuse; and to empower women. Lyric analysis can also serve as a first step in the music therapy method of song writing (See the *Guidelines for Compositional Music Therapy* section later in this chapter for further details). The level of therapy involved is intensive or primary. While no specialized training is needed to use this method, experience with in-depth verbal processing and concomitant skills in dealing with intense emotions which may arise would be beneficial. A deep understanding of the issues involved in violence against women and the diverse experiences faced by abused women is critical, as is cultural humility.

Preparation. As with most music therapy methods used with abused women, the location should be a quiet, private space with comfortable seating typically arranged in a circle, and with a door which can be closed to provide a sense of safety and minimize outside distractions. A wide selection of music representing diverse music genres/styles is essential; the particular clients may determine the genres and styles needed. This collection typically starts with the music therapist's own choices and then grows rather organically, as clients make requests and, in my case, colleagues made many suggestions hearing about my area of practice. Encouraging clients to bring in their own music provides a wonderful opportunity which should not be overlooked, particularly when working in a cross-cultural context. In bringing their own music, clients are accorded the role of experts in their own music, their own experiences, and their own experiences of

violence. The music provides an invaluable vehicle for bridging cross-cultural barriers. For the therapist, having the music organized on an iPod or iPad (with accompanying high-quality docking station stereo) can be very helpful; having the original CDs, with cover artwork and inserts also enhances the experience.

For the client, having a copy of printed song lyrics for all songs is a must. With the lyrics organized alphabetically in a binder (one for each client) with a Title Table of Contents and a Thematic Index, clients (and therapists) can easily find the ideal song for the moment and new songs can be readily added as clients make suggestions. Depending on the setting and the budget, clients may keep these Song Lyric Binders with them throughout the week between therapy sessions. A separate Song Lyric Binder for the music therapist is helpful as it can include chords for piano or guitar accompaniment as well. Clients may also have access to recordings of the music, again depending on the setting and the budget, with possible purchases through iTunes. The selection of the songs and their themes is individualized by the therapist to meet the purpose of the particular music therapy group. Specific examples of music selections by theme are provided below in the *Possible Adaptations* section.

What to Observe. The focus of the music therapist's observations within this music therapy method is quite varied and can include: client engagement in the process (in selection, discussion, or recommendations of songs); response to the music and to other group members; verbal responses; themes, memories, and experiences that arise and are shared; and nonverbal responses such as facial expressions, demonstrations of emotions, and moving or singing to the music.

Procedures. The session can start with a preliminary client check in, followed by distribution of the Song Lyric Binders. The choice of songs and their themes may develop out of any check-in themes, or they may be selected by the therapist or the clients. In some settings, the format is a drop-in one, with different clients each week and a different *stand-alone* theme predetermined by the therapist; in other settings, attendance may be ongoing over a period of time and themes develop organically to meet the needs of the group as it progresses. However the themes are determined, clients should have the opportunity for their own choice of song within that theme. Within the session, each song can be first listened to on the recording; then sung along by all with the recording, and finally sung along with the therapist as she accompanies the group. This moves the music therapy method from a Receptive method to a re-creative one (See the later *Guidelines for Re-Creative Music Therapy* section for more details). Each of the three ways of experiencing the song offers important unique contributions to the therapeutic process.

In listening to the recorded music, clients hear the voices of other women and their experiences of violence; this breaks their social isolation and allows them an understanding that they are not alone in experiencing violence. In singing along with the recorded music, clients can begin to internalize the message and the emotions of the song. Additionally, the recorded song provides support, especially important in the initial stages of involvement in music therapy, as well as for those whose self-esteem is not yet strong; group singing enhances a sense of group cohesion. In singing along with the music therapist, the clients can move to making the song, and the story, their own, embodying the experience. The use by the clients of their own voice, and the experience of truly being heard, can be very beneficial for abused women, women who have not

been heard in the past—by their abusers or by others who have failed them (Curtis, 2000, 2006, & 2008; York, 2006).

Throughout all of the three phases of experiencing the song, the music therapist will facilitate and support discussion of the song and the themes which arise. While the therapist may make use of some open-ended questions, it is further helpful if the therapist sees this as a dialogue rather than a series of questions. This can work to establish a relationship of give-and-take, with a more egalitarian relationship in terms of power. This can be critical in the healing process for women whose experiences of violence have been characterized by abuse of power and control. An example of phrasing used by the therapist which fosters a dialogue, rather than questions would be, “what struck me while listening to this song was . . .” or “I was wondering if this part of the song evoked a strong emotion for anyone else . . .” In this approach, a certain amount of appropriate self-disclosure can enhance the therapeutic process (Worell & Remer, 2003).

Adaptations. One adaptation of this method involves feminist analysis of gender-role socialization and power through lyric analysis (Curtis, 2000, 2006, & 2008; York, 2006). This feminist analysis is a signature technique of Feminist Music Therapy, making use of a number of music therapy methods including lyric analysis, music-centered relaxation, song writing, recording, and performance. The goal of each is to increase women’s understanding of the sociopolitical underpinnings of violence against women—in general terms and in specific terms as they apply to the clients’ experiences; the goal is also to examine the role of women’s and men’s gender-role socialization and power within the context. To accomplish this in lyric analysis, the music used is typically music written and/or performed by women. This makes it easier for the clients to see and hear themselves in the music. The themes selected for this work are broad ranging and can include women’s voices on: violence, anger, change, control, freedom, gender-role socialization, healing and recovery, love and romance, needs, self, strength, support, and truth telling. There is a wealth of popular songs in diverse styles available for this method. Online resources can be helpful such as Lady Slipper Music at <http://www.ladyslipper.org/>; so too can the annual editions of the Grammy Nominees. A partial listing of women’s songs by theme follows.

Theme of Being Alone:

All by Myself, Jamie O’Neal
Sand and Water, Beth Nielson Chapman

Theme of Anger:

Bitch with a Bad Attitude, Saffire Uppity Blues Women
Goodbye Earl, Dixie Chicks

Theme of Change

Do Something, Macy Gray
Pissin’ on a Skunk, Saffire Uppity Blues Women
Why? Tracy Chapman

Theme of Control

Don’t You Tell Me, Saffire Uppity Blues Women

Theme of Freedom

Dear Someone, Gillian Welch
Dreaming on a World, Tracy Chapman

Going Out Tonight, Mary Chapin Carpenter
Theme of Gender-Role Socialization
 Equal/Equally, Parachute Club
 Good Thing He Can't Read My Mind, Four Bitchin' Babes
 He Thinks He'll keep Her, Mary Chapin Carpenter
 If I were a Boy, Beyoncé Knowles
 Women's Work, Tracy Chapman
Theme of Healing and Recovery
 Blackbird, Sarah McLachlan, Dionne Farris
 Broken Wing, Martina McBride
 Get Up Blues, Joyce and Jacque
 Hope, Sweet Honey in the Rock
 Love's Recovery, Indigo Girls
Theme of Leaving/Staying:
 Dump that Chump, Saffire Uppity Blues Women
 Let Him Fly, Dixie Chicks
 Sun Comes Up, It's Tuesday Morning, Cowboy Junkies
 When the Heartache's Over, Tina Turner
Theme of Love:
 Any Man of Mine, Shania Twain
 Exhale, Whitney Houston
 Not the Doctor, Alanis Morissette
 Passionate Kisses, Mary Chapin Carpenter
 You Say You Will, Trisha Yearwood
Theme of Self:
 Not a Pretty Girl, Ani DiFranco
 Video, India Arie
 Woman's Worth, Alisha Keyes
Theme of Strength:
 Bitch, Meredith Brooks
 You Learn, Alanis Morissette
Theme of Truth Telling:
 Telling Stories, Tracy Chapman
Theme of Violence:
 Behind the Wall, Tracy Chapman
 Bonnie and Clyde '97, Tori Amos
 Don't ever Touch Me [Again], Dionne Farris
 She Won't Be Walking, Four Bitchin' Babes

Another adaptation of the Lyric Analysis method is its use as a first step in song writing. With this adaptation, the focus in listening to and performing songs changes. In addition to looking at the themes, attention is directed to how the song is written in terms of both the lyrics and the music. The purpose is to assist clients later as they move into writing their own original compositions (See the *Guidelines for Compositional Music Therapy* section which follows later). This can be an important opportunity to set clients minds at ease if they are uncertain about the song writing process. Clients will come from

diverse backgrounds, many of whom may be insecure about their English language skills, possibly making writing intimidating. Fears can be allayed in listening to song examples, such as Tracy Chapman's *Behind the Wall*, which are written in simple language; clients can be encouraged to use their own speaking style, and find their own authentic voices in this process.

Bonny Method Guided Imagery and Music (BMGIM)

Overview. BMGIM involves the client (traveller) listening to classical music programs in an altered state while dialoguing with the therapist (guide) about the images and sensations that are evoked. Recent research has shown BMGIM to be effective with women survivors of intimate partner violence under certain circumstances (Hahna & Borling, 2004). However, a careful assessment of the severity of the violence and an indication of the last incidence are needed, with contraindications for those with any disassociation. Training in the BMGIM method is required and additionally those trained must have awareness of issues surrounding intimate partner violence. Further information about BMGIM training can be found at <http://www.ami-bonnymethod.org/>. Because extensive BMGIM training and credentialing is required, this section will be limited to an overview with a focus on the particularities of the practice of BMGIM as it is used with abused women (Hahna, 2004; Hahna & Borling, 2004; Ventre, 1999). The overall goal of BMGIM is for individuals to “integrate mental, emotional, physical, and spiritual aspects of themselves” (AMI, 2012a, para. 1). It is “the conscious use of imagery which has been evoked by relaxation and music to effect self-understanding and personal growth processes in the individual” (Hahna & Borling, 2004, p. 44). The level of therapy is primary.

Preparation. The location used for this method should be a quiet, private space which is conducive to BMGIM—comfortable seating, a place to stretch out while listening to recorded music, a place for the making of artwork (mandala drawing), appropriate lighting which can be dimmed as needed, and a door which can be closed to minimize outside distractions. A high-quality sound system and art supplies are required. In preparation for BMGIM work, the therapist must have successfully completed all requirements of the Association for Music and Imagery.

What to Observe. Detailed notes are taken during and after each BMGIM session documenting the client's words, imagery, and responses (verbal and nonverbal).

Procedures. In broad terms, BMGIM is “the use of specially sequenced western classical music designed to stimulate and sustain a dynamic unfolding of imagery experiences” (AMI, 2012b, para. 2). BMGIM sessions are conducted in individual therapy, in 2-hour sessions with a format comprised of four parts (Hahna, 2004; Ventre, 1999): 1) prelude or preliminary conversation; 2) induction; 3) music program, and 4) postlude or integration/processing which can involve art work in the form of mandala.

Adaptations. In reviewing the practice of BMGIM, Hahna & Borling (2004) note that certain adaptations are needed in work with women survivors of intimate partner violence: 1) shortened music programs; 2) less intense music programs at the initial stages; 3) longer session duration; 4) client support with relaxation; and 5) greater client control. Of the BMGIM music programs, *Mostly Bach* is seen as one of the most helpful, but it is contraindicated at the beginning, trust-building stage of therapy. Additionally,

current knowledge of intimate partner violence, including assessment and safety issues is critical; feminist approaches to the BMGIM work are recommended (Hahna, 2004; Hahna & Borling, 2004).

Guidelines for Improvisational Music Therapy

Group Music Improvisation

Overview. This involves creating music extemporaneously in a group with the voice or instruments with or without a theme. Most women survivors of violence can benefit from group improvisational music therapy, instrumental and/or vocal (Amir, 2004; Austin, 2001; Slotoroff, 1994). The intensity of the experience and the degree of client engagement can be modified by the therapist to meet the ability and needs levels of the client. Challenges can arise, depending on the client, around issues of self-esteem, and physical and emotional responses evoked, as well as around participation in this type of music making for those inexperienced with it. These can be handled by a skilled music therapist with forethought and attention. Caution is advised to first ensure that a safe place has been successfully established for each client in therapy, prior to undertaking this method.

Goals used with this method are diverse and can include opportunities for body work (many of the effects of this type of interpersonal trauma can reside in the survivor's body), for expression of emotions, for being heard and validated, for building self-esteem, for building group cohesion and breaking social isolation, and for empowerment. Depending on the particular application of this method, the level of therapy can be intensive or primary. While no specialized training is needed to use this method, experience with in-depth verbal processing and skills in dealing with intense emotions which may arise can be beneficial. Furthermore, experience and skills in facilitating group music improvisations can be helpful—this includes music and verbal skills.

Preparation. For group instrumental improvisation, a good collection of high-quality instruments intended for adults is essential. This ensures that each client feels respected and honored in the therapeutic process. The instrument collection should include instruments of a variety of sizes as well as types—pitched and non-pitched, handheld and free standing (on the floor or in adaptive stands), of definite and indefinite rhythmic sounds (e.g., drums hit with the hand or mallet, shakers, ocean drums, etc.), small, intimate instruments and large, powerful ones such as large djembes or Japanese traditional taiko drums. The instruments can be arranged in the center with client chairs placed in a circle around them. In selecting the particular instruments for use, the therapist needs to be sensitive to multicultural issues and may need to consult with individual clients. Some are not comfortable with traditional Native American drums in the hands of white people. This can, however, be a teachable moment where the clients can be the experts once again in their own music and culture. The room itself needs to be soundproofed or in a location such that sound transfer does not pose a problem for others, thus permitting freedom of musical expression within the group.

What to Observe. During the course of the session, the music therapist makes observations on musical and non-musical levels. On the musical level, observations can include verbal and nonverbal responses such as: choice of instrument, approach in

playing (e.g., hesitant, forceful, quiet, loud, etc.), interaction with other group members, participation in the structured portions, participation in the non-structured portions. On the non-musical level, observations can include emotional responses (verbal and nonverbal), connections made within the improvisation to any established therapy topics, and themes that arise in the post-improvisation discussions.

Procedures. If this is the first experience of the day's session, it starts with an opportunity for clients to check in. Issues that might arise are noted for possible inclusion in the group music improvisation. The session start up might also include warm up singing of a song or a simple chant to set the mood, establish a sense of group cohesion, and help clients to focus. An introduction to the group improvisation experience is then provided for first timers, along with brief guidelines in performance and/or sounds of the instruments as needed if the group is new, or if members of the group are new. In the case of a new group, the group music improvisation can be moved by the therapist from a more structured experience to a freer type of improvisation; while the choice is theirs, the clients may equally be guided as needed to move from smaller instruments to more powerful ones.

For some who are new to improvisation, the experience can initially be intimidating, and so this guidance from the therapist can provide the needed support. In a more structured improvisation, the music therapist may provide a basic beat or rhythmic ostinato and then invite the group to join in playing it. Once the group is comfortable and the rhythm well established, an opportunity is provided that is built into the structure of regular musical phrases for free improvisation, followed by a return to the structured ostinato. The group then alternates regularly between structured playing and free improvisation. Initially, the free improvisation can be done by all members of the group, then in smaller groups, trios, then duos, then solos while the remaining group members play the ostinato or keep the beat. This allows the clients a sense of safety and support, moving to greater independence as their confidence builds.

The improvisation may be *referential*—i.e. focused on a theme—one chosen ahead for the day or one that emerges out of the preliminary check-in discussion. Alternately, the improvisation may be *nonreferential*, i.e. may commence musically, without a predetermined theme, allowing clients' emotions and responses to emerge organically. The improvisation is allowed to unfold naturally, drawing to a close at the clients' discretion. The improvisation is concluded with an opportunity for verbal processing of the experience. As with the previous Lyric Analysis method, this should be more within a dialogue framework than an educational or question-and-answer framework. In work with abused women, effort must be taken to facilitate a client-therapist relationship which is as egalitarian as possible. Ultimately, the women are experts of their own experiences and can accomplish their own healing and recovering with the support provided by the music therapist and with interactions with other survivors and the music therapist.

Adaptations. While the above music therapy method is described with instrumental improvisation, it can play out equally well with vocal improvisation. In this case, the music therapist may or may not provide support with an accompaniment instrument like guitar or piano, or hand held drum. The voice is a particularly intimate and revealing instrument, and its use in improvisation may therefore be more intimidating for some clients; when used appropriately, it can be an incredibly effective

medium for women's empowerment, providing a real and authentic voice, as well as the metaphoric voice gained in the healing process. As with instrumental improvisation, the therapist can guide clients in vocal improvisation moving from more structured to freer improvisation. Starting with a familiar song or a simple chant (either existent or composed by the therapist for the improvisation) can also provide clients with needed support. The chant might have words in keeping with an established theme, or it might be sung without any words.

Individual Music Improvisation

Overview. Individual music improvisation involves creating music alone or with the therapist extemporaneously using voice or instruments with or without a theme. Some women survivors of violence can benefit from individual improvisational music therapy (Amir, 2004; Austin, 2001). This method is not recommended for those in need of work on breaking their social isolation which can best be accomplished in hearing the voices of other abused women in group therapy. It is also not recommended at the beginning stages of therapy where trust building is still underway. Austin (2001) provided case study examples with this method which, because of the method's intense nature, first involved lengthy periods of preliminary work prior to the start of individual improvisation.

As with group music improvisation, goals used with this method are diverse and can include opportunities for expression of emotions, for being heard and validated, for building self-esteem, for exploration of issues surrounding the experience of violence; for bringing to the conscious thoughts, feelings, and memories of the trauma, and for the subsequent processing of these in a safe, environment; and for empowerment. Depending on the particular application of this method, the level of therapy can be intensive or primary. While no specialized training is needed to use this method, experience with in-depth verbal processing and skills in dealing with intense emotions which may arise can be beneficial. Furthermore, experience and skills in facilitating individual music improvisation can be helpful—this includes music and verbal skills.

Preparation. As with other described music therapy methods used with abused women, the location should be a quiet, private space. The individual music improvisation can be vocal, instrumental, or some combination used by therapist and client together. The room can be arranged with a small collection of instruments representing a variety of sizes as well as types, as described in the previous section on group music improvisation. The instruments can be arranged in the room adjacent to a piano or guitar, for possible use in accompanying the improvisation.

What to Observe. Similarly to group music improvisation work, the music therapist makes observations on musical and non-musical levels. On the musical level, observations can include: choice of instrument, approach in playing (e.g., hesitant, forceful, quiet, loud, etc.), participation in the structured portions, and participation in the non-structured portions. On the non-musical level, observations can include emotional responses (verbal and nonverbal), connections made within the improvisation to any established therapy topics, and themes that arise in the post-improvisation discussions.

Procedures. Again the procedures for conducting individual music improvisation are similar to those used in the group improvisation. The session may start with a client

check-in, possibly identifying themes for the individual improvisation to come. The music therapist guides the client through the session moving from more structured experiences to freer improvisation. If vocal improvisation is used, great care must be taken to gradually ease the client into it, because the voice is such an intimate and revealing instrument. The therapist may choose to start with the singing of a familiar song. She may then introduce the client to a simple chant; possible options include a traditional chant such as a Native American women's chant (Smithsonian Folkways, 1995), depending on the client's cultural background, or a chant with simple melody and words composed by the therapist specifically for the client. Drum, guitar, or piano may be used optionally to provide grounding and support. Once the client is comfortable engaging in the music at this level, the music therapist can gradually guide her to further experimentation, adding her own words or musical lines, or singing without words.

As with the group music improvisation methods described previously, the improvisation may be focused on a theme (client or therapist choice) or it may start without a predetermined theme, allowing the client's emotions and response to emerge freely. Themes selected by the therapist will focus on issues appropriate to the individual client's progress within therapy; these may include: reflections on the experience of trauma/violence; healing and recovery; coping strategies; and dealing with the responses of others. Themes selected by the client may be identified in discussion immediately prior to the improvisation or in previous work in earlier music therapy sessions. The music therapist provides musical support in improvising with the client, at times mirroring the client's musical and emotional content, while at other times extending it. The improvisation is allowed to unfold naturally, drawing to a close at the client's discretion. The improvisation is concluded with an opportunity for verbal processing of the experience.

Adaptations. In a psychoanalytic approach to improvisation with survivors of abuse, Amir (2004) outlines three possible adaptations used with individual rather than group improvisation: 1) an improvisation paired with reading, 2) a projective improvisation; and 3) a musical life story improvisation. The purpose of each of these adaptations is to bring issues to the conscious, to process the trauma, and to facilitate the healing process. With the first adaptation, the client reads a book while improvising; this is designed so that the client is not focusing on the improvisation itself; in this manner, the client can reflect on and access unconscious material. The second adaptation involves short projective improvisations played by the client in response to words provided by the therapist. The words presented by the therapist move from less evocative to more evocative (e.g., sky, ground, sun, then power, anger, etc.). In the final adaptation, the client plays an improvisation which reflects her life story. Verbal processing is an integral part of all three of these adaptations.

As part of her approach with women trauma survivors, Austin (2001) outlines several individual vocal improvisation music therapy methods: Vocal Holding techniques and Free Associative Singing. Austin developed and codified these as part of her Vocal Psychotherapy practice. The level of therapy involved is primary and preparation for this practice requires advanced training; more information about the method and training is available at <http://diane-austin.com/music/>. As a result, what follows here is a brief description only. Austin's Vocal Holding technique makes repetitive use of two chords along with the music therapist's voice to create a safe musical container to support

improvised singing of the client in interaction with the therapist. The purpose of this method is to allow access to and processing of unconscious material arising from the trauma. In describing this method, Austin indicates that the client and therapist start with unison singing for support and then move to harmonizing reflective of the client's readiness to be separate but in relationship. Free Associative Singing arises when words are introduced to the vocal improvisation. In this approach, the client sings whatever words come to mind and the therapist contributes musically and verbally to the stream of consciousness. In this manner, the therapist serves as both a container to hold and a force to further the therapeutic process.

Guidelines for Re-creative Music Therapy

Reflective Singing

Overview. In reflective signing, clients are engaged in singing with the therapist along with the original recording of a song. This method is indicated for clients as a preliminary step in song writing and in individual vocal improvisation, and as a follow up step in the lyric analysis method. There are generally no contraindications if handled skilfully by the music therapist. The goals include allowing clients: to internalize the emotions and experiences reflected in the song; to gain a deeper understanding of the song's theme and musical structure; to gain an understanding of the songs' themes as they relate to the clients' own experiences; and to achieve a sense of safety in the therapeutic relationship prior to individual vocal improvisation work. The level of therapy can be augmentative or intensive. No specialized training is needed on the part of the music therapist, however strong music and verbal processing skills are needed.

Preparation. As with other described music therapy methods used with abused women, the location should be a quiet, private space. Appropriate room and acoustics for vocalizing is needed, along with a high-quality stereo system and such accompanying instruments as guitar and piano.

What to Observe. The focus of observation will depend on the purpose of the method, but will include musical and non-musical observations, as well as verbal and non-verbal ones. The music therapist will be looking to see that the client is ready to move to the advanced level in song writing and in vocal improvisation. Comfort and participation levels will be observed. Verbalizations concerning ideas, themes, memories, and insight will be observed as they are evoked by the music.

Procedures. With use of reflective singing in preparation for song writing and in culmination of the lyric analysis methods, clients will be engaged in singing with the therapist along with the original recording of a song. Songs will be selected according to themes identified by the music therapist and/or the clients. Focus may be directed to the musical structure, as well as to the emotions evoked and experiences described through the song. Verbal processing may completed after each song.

With reflective singing used in preparation for later individual vocal improvisation, the music therapist may sing songs to the clients, or the clients themselves can sing—alone or with the therapist. Austin (2001, p. 137) describes songs as “a container that has a beginning, a middle, and an end. . . . The song can be a catalyst for buried emotions while also providing a container for them.” In singing songs with and

for the client, the music therapist works to build a trusting therapeutic relationship. Once this is accomplished, she may move on into vocal improvisation with the client. This method can be used in an individual or group setting.

Performance

Overview. In performance, clients select pieces, practice them, and perform them for an audience. This method can be appropriate for clients who have already progressed considerably in therapy. Clients need both adequate personal and musical/performance skills in order for successful engagement in this method (York, 2006). Goals for this music therapy method include: increasing self-expression, self-esteem, self-advocacy, and social justice activism. The level of therapy is augmentative or intensive. No specialized training is needed on the part of the music therapist, however strong music and performance skills are needed, as well as an understanding of social activism work.

Preparation. This performance method is typically the final product of the music therapy process involving client creation of their own original music, artwork, poetry, and play scripts. As a result, the music therapist works with the clients to gather and select the pieces they will perform.

What to Observe. In terms of the non-musical, the music therapist will observe clients' verbal and nonverbal indications of comfort and preparedness for a performance. Music and performance abilities will be evaluated as they progress over the rehearsal period. Indications of group interactions and group cohesion can also be observed. While the final performance is one of the goals of this method, the importance of client progress within the rehearsal process cannot be underestimated.

Procedures. This method should start with consensus building among the group as to the purpose, the process, the performance materials, and the final venue of the intended performance. Once these have been established, along with rehearsal dates and schedule, each session may include: 1) a group member check-in; 2) physical and vocal warm ups; 3) rehearsal of the performance materials; 4) wrap-up session, with an opportunity for feedback from group members. At various points within the rehearsals, there may need to be full and sectional rehearsals. Closer to the performance, session time may also include staging, choreography, and dress rehearsals. The duration, frequency, and nature of these sessions may vary considerably depending on the initial decisions concerning the originally agreed-upon purpose and venue of the final performance. In some instances, the performance can be used in increasing public awareness and social activism. The performance may then be followed by a discussion period between performers and audience members (York 2006).

Adaptations. This method can involve pure music performances or interdisciplinary arts performances which can include music, theatre, and artwork. Performances may be done in a variety of contexts, from private settings, to performances for family members, at a selected agency, or open to the public.

Guidelines for Compositional Music Therapy

Song Writing and Recording

Overview. In song writing and recording, clients work individually or in a group to write a song on a therapeutic theme, then perform and record it to listen to themselves sing it. One of the most powerful methods for enabling abused women to be heard, to reclaim their voices and their lives, is through song writing. It is a method used widely by most working with survivors of violence (Curtis, 2000, 2006, & 2008; Cassity & Theobald, 1990; Day, Baker, & Darlington, 2009; Whipple & Lindsey, 1999). Song writing in this area has been approached both within individual and group therapy settings. Talking and writing about women's experiences of violence in the process of song writing can evoke very powerful emotions and memories; it can also evoke, on the other hand, great resistance. Once again, great caution must be taken to first ensure that a relationship of trust has been successfully established with each client in therapy, prior to undertaking this method. The preliminary use of lyric analysis and re-creative methods in trust building can be helpful to ensure that the client is ready to proceed to work using this method.

The goals achieved through this method can be varied depending on the approach, and may include: expression of emotions; exploration of issues related to the experience of violence and its impact; giving voice to experiences of violence and truth telling; validation and empowerment; exploration of effective coping strategies and stress management skills; increasing self-esteem; breaking social isolation; and increasing understanding of gender-role socialization and power, along with the role these play in the clients' lives. The level of therapy involved can be either intensive or primary. While no specialized training is needed to use this method, experience with in-depth verbal processing and skills in dealing with intense emotions which may arise can be beneficial. As with lyric analysis, a deep understanding of the issues involved in violence against women and the diverse experiences faced by abused women is critical, as is cultural humility.

Preparation. In addition to the traditional quiet, private space needed for most work with abused women, for this method the therapist may choose to have on hand a whiteboard and/or individual writing journals for each client. The music therapist should also have on hand: a good sound system, with an appropriate selection of recorded songs; accompaniment instruments such as keyboard or guitar; and other small percussion instruments as needed. The song writing session is best prepared for by engaging the clients previously in lyric analysis and vocal improvisation experiences focused on the experiences of both the songwriter and the client, and allowing the client to feel more comfortable and supported for the song writing experience.

What to Observe. The music therapist can observe a full array of musical and non-musical responses, verbal and nonverbal responses. These can include: engagement in the process; level of comfort with various segments of the experience (making suggestions, writing, volunteering ideas); ideas, theme, memories, and experiences that arise; interactions with other group members; any insights gained in connections to the songs used in lyric analysis, the clients' own experiences, and any themes established for therapy.

Procedures. Song writing is typically an extended music therapy method which extends over several sessions. It can, however, be modified on occasion to be completed within a single session depending on client skills and needs. This method can involve writing as a group, individual writing within the group, or some combination. Having

completed previous work (in this session or proceeding ones) on lyric analysis, singing, and some simple vocal improvisation, the music therapist and clients are ready to start the song writing experience. Without adequate preparation, song writing may seem daunting at first, particularly for abused women whose voices have been silenced and whose self-esteem has been the target of much violence. A helpful approach to address this involves moving gradually from simple, structured writing to more complex, freer writing. This transition—in terms of both lyrics and music—enhances the development of skills, confidence, and self-esteem.

In an example of writing at its simplest, clients can be directed to individually write five sentences in their journals as follows: 1) one word that is the song's theme; 2) two words that are synonyms of the first; 3) three words that are adjectives of the first; 4) four words that are descriptive gerunds (ending in "ing"); and 5) the first word repeated (the song's theme). Depending on the clients, the therapist could select the song's theme and first word to be the client's name. These five lines are suitable as lyrics for use with a 12-bar blues pattern. Clients are asked if they are willing to share their writing, and those who agree have their first writing sung to them by the music therapist. If in agreement, the lyrics can be written on the whiteboard and the entire music therapy group can sing them. Alternately, clients could work together using this method to write a single song, making use of the whiteboard. Whichever approach is used, an opportunity for verbal processing follows, addressing both the song writing process and any emotions or themes that are evoked. Work with this method has shown clients to be consistently open to this process, delightfully surprised at the ease of their writing, and genuinely pleased with their first song (Curtis, 2000).

The music therapist can then move to the next phase in song writing, making use of a longer *Clozé (cloze)*, or fill-in-the-blank, technique. Clients are involved in adding single words or complete sentences to pre-composed songs. Certain songs lend themselves readily to this because of the structure of their lyrics and melody, although care must be taken to choose songs such that the experience is mature, not childish. Examples of these include Alanis Morissette's *Hand in My Pocket* and Edie Brickell's *Oak Cliff Bra*. Ultimately, clients can gain more satisfaction in working with original music so the songs they create are their own. To facilitate this, music therapists can write their own songs to be used by the clients at this stage.

Once clients have successfully and confidently completed this work, they are ready for the next phase which involves writing their own completely original lyrics and/or music. Typically clients are more comfortable starting with the lyrics and then building the music around these. In doing this, they working individually within the group, bring back their ideas and writings to the group for feedback and support. At this stage, themes for individual songs are selected by each client, with ongoing support of the music therapist. Throughout this process, part of each session can be spent in listening to and performing recorded songs which can provide ideas and inspiration. Depending on the skills and interests, clients may choose to write their own music (assisted in singing improvisation work with the therapist) or have their lyrics set to music by the music therapist, with feedback and choices made by the client. Throughout each of these phases in the song writing process, ample time and opportunity is allowed for verbal processing.

Clients can benefit greatly when the song writing experience ends with recording of their songs. The music therapist should secure an informed consent form from each client prior to completing any recording. The recording may be done by the client or by the therapist, at the client's discretion. Fairly modestly-priced home recording studio equipment is now available commercially to ensure a high quality final CD. Clients can be also involved in the process of creating the artwork—either hand drawn or computer-generated images—for their CDs. As a whole, the song writing/recording method provides an ideal therapeutic medium for abused women in having their voices heard and in re-claiming their unique authentic voices

Adaptations. Some adaptations of the song writing/recording have already been described in the previous section including individual work versus group work, more structured versus structured work, and work within and outside the therapy group. This method is widely used in work with abused women and its use has been adapted with great diversity in terms of the selected therapeutic goals: to enhance communication, expression of emotions, psychoanalytic insight, and feminist analysis of gender-role socialization.

Closing Remarks on Methodology

The procedures described above in each of the methods have been conceived as complete sessions. Nevertheless, different parts of sessions may be combined depending on the needs of clients. In this section, the procedures are summarized and options for combinations of different procedures are presented.

The music-centered relaxation group includes a variety of experiences including breathing, progressive muscle relaxation (PMR), and guided imagery. After a check-in discussion the therapist begins the music-centered relaxation experiences gradually moving from the least demanding—breathing—to progressive muscle relaxation (PMR), and finally, to the experience that involves the psyche most deeply—music-centered guided imagery. This sequence is designed to assist the clients to gradually let go of their anxieties and to access their inner resources. However, the therapist may also use the initial breathing exercise as an opening for other groups, and may use the breathing and PMR without the music-centered imagery experience depending on the particular needs of the clients. These techniques can be used both in the individual and group setting. For therapists with specialized training working in individual sessions, the Bonny Method Guided Imagery and Music (BMGIM) might also be used; this process by definition proceeds through discussion, relaxation, music imagery, and back to discussion phases, incorporating an array of receptive techniques.

While improvisation may be the main focus of a particular session, other methods are also used to establish group cohesion and establish a focus for the improvisation, for example, beginning with a discussion, and then proceeding with singing or listening to a song or a simple chant. This format can be used with both groups and individuals. Similarly, with sessions involving the use of songs, various methods are often combined. For example, lyric discussion may involve listening to songs, but also singing them. In some situations, writing new lyrics to the song might also be therapeutically indicated, thus moving from receptive through to re-creative and compositional methods. Clients may also perform songs that are meaningful to them or songs that they have written after

working on them in sessions. Each session has a life of its own depending on the group composition or the individual, the issues that are revealed, and the energy of the participant(s). The sequences of therapeutic procedures presented herein represent some possible groupings, but there are infinite combinations available.

Research Evidence

Research evidence in the area of music therapy with women survivors of abuse is limited in keeping with this area's emergent nature. Of the existent literature, the majority is comprised of anecdotal and case-study reports. Whether more formal research or anecdotal, most examines the effectiveness of some combination of music therapy methods, with only a smaller portion dedicated to examining single methods.

Receptive Music Therapy

Laswell (2001) and Hernández-Ruiz (2005) identified the effectiveness of music-assisted relaxation in increasing relaxation, decreasing anxiety, and improving sleep for abused women at shelters. Within a randomized control trial, 28 women participated in a music-assisted relaxation protocol involving a 20-minute recording of participant-selected music combined with a progressive muscle relaxation script over a period of five consecutive days (Hernández-Ruiz, 2005). Pre-test/post-test measures showed: an increase in sleep quality as measured on the Pittsburgh Sleep Quality Index (PSQI); a decrease in anxiety levels as measured on the State-Trait Anxiety Inventory (STAI), and an improved overall quality of experience for all of the women.

In a narrative case study report, Rinker (1991) described the effectiveness of Bonny Method Guided Imagery and Music (BMGIM) for a woman survivor of intimate partner violence. Over a 4-month period, the woman showed improvement in her confidence, strength, and empowerment. Similarly, Ventre (1994) provided a narrative report on positive outcomes for an abused woman participating in BMGIM for two years. In later research, Hahna (2004) found a feminist approach to BMGIM with women survivors of intimate partner violence to be effective in improving their empowerment as measured on the Personal Progress Scale Revised.

Improvisational Music Therapy

In description of her clinical work with a 32-year old women survivor of childhood sexual abuse, Amir (2004) identified the positive outcomes of improvisational music therapy, highlighting its ability to give "trauma a voice and bring harmony to the soul" (p. 103). Austin's case study work (2001) described the particular effectiveness of vocal improvisation techniques with adults who have been traumatized as children.

Compositional Music Therapy

The music therapy method of song writing was examined by Day, Baker, and Darlington (2009) for its use with mothers who had experienced child abuse. This qualitative research involved in-depth interviews of five women three years after their participation

in a song writing experience embedded within a parental support program. All reported positively on their song writing experience; for most, song writing and listening to those songs afterwards served to facilitate communication with others, enhance self-esteem, and allow reflection on their resolution of past harm.

Multiple Methods of Music Therapy

Montello (1999) provided a narrative account of the effectiveness of a combination of music therapy methods she used in clinical case study work with adults traumatized as children. Similarly, Austin (2006) described her use of several music therapy methods, including breathing exercises, song singing, vocal improvisation, and psychotherapy. She outlined this Vocal Psychotherapy approach and its positive outcomes through clinical vignettes from her work with adults traumatized as children.

In a research protocol which evaluated effectiveness of an 8-week music therapy program for women at battered women's shelters, Whipple and Lindsey (1990) found that all 15 women participants responded positively. Relaxation, feelings about self, and feelings about the situation were measured on a 5-point Likert scale. The most effective music therapy methods included: group singing which improved mood and social interaction; song writing for improved communication; and experience sharing and drawing for improved self-esteem. The effectiveness of group music therapy using multiple methods was further evaluated within a research design with women at a shelter for domestic violence (Fesler, 2007). Of the three women completing the study, all benefitted with increased self-confidence and positive changes on the posttraumatic Symptom Checklist 90 Revised (SCL-90R).

Multiple music therapy methods which also included the use of creative arts were examined for their effectiveness with seven women who had experienced intimate partner violence (Teague, Hahna, & McKinney, 2006). Results, using Visual Analogue Scales (VAS), showed a significant decrease in depression and a moderate decrease in anxiety. Most participants identified all of the music therapy methods as helpful, including: Use of singing bowls, journaling, clay work, lyric analysis, singing, and song writing.

Several recent studies examined the effectiveness of Feminist Music Therapy with multiple music therapy methods for women survivors of violence (Curtis, 2000, 2006, & 2008; Curtis & Harrison, 2006; York, 2006). Curtis (2000) described her development of this new approach and reported on a research study evaluating its effectiveness as applied specifically in group therapy with women who had experienced intimate male partner violence. For the six women completing the study, five showed significant improvements in their Tennessee Self-Concept Scale scores (TSCS), and all showed improvements as measured in post-therapy interviews and analysis of their composed lyrics. Music therapy methods adapted for use in Feminist Music Therapy included: Music-centered relaxation, lyric analysis, singing, song writing, performance, and recording. Curtis (2006 & 2008) provided further descriptions and narrative reports of the use of these methods with diverse women in feminist music therapy. A follow-up research study examined the effectiveness of a collaborative approach using Feminist Music Therapy and feminist social work with adult women survivors of childhood sexual abuse (Curtis & Harrison, 2006). The therapy methods used were expanded to include

those previously identified as well as journaling, CD art work, genograms, and discussions led jointly by music therapist and social worker. All five women participants showed significant increases in their self-esteem as measured on the TSCS and in exit interviews.

York (2006) examined her own feminist approach to music therapy expanded in collaboration to incorporate psychoeducational and psychodrama elements. In this clinical qualitative research, eight women survivors of domestic violence participated in group music therapy weekly for eight months, and showed decreased anxiety, and increased self-esteem, positive interactions, and risk-taking.

Summary and Conclusions

This chapter has explored the information, knowledge, preparation, and skills needed for effective and culturally-sensitive practice with women survivors of violence. A preliminary look at the incidence rate and the effects of violence against women has shown its impact to be significant at both personal and societal levels. Information has been provided concerning diagnosis, along with surrounding controversies. While not yet resolved, these highlight the importance of sociocultural and political underpinnings. Whether or not women who have experienced such violence should be or will be diagnosed, music therapists can expect to see a number of them in their practice during their careers—whether or not those careers are specifically in trauma work.

The diversity of women's experiences of violence has been identified, looking at the full range of their characteristics (seen not as pathological symptoms, but as responses to extraordinary violence). Women's strengths and resilience in light of this violence are noteworthy, and can include: effective and active use of coping strategies, empathy for others traumatized, and a passion for social justice and activism. Women's responses to the violence have been shown to be as diverse as they are, and can include intrusion, avoidance, negative cognitive or mood alterations, and arousal or reactivity alterations. Shown to be equally diverse is the amount of time and support needed to recover from the harm of this violence. An understanding of these complex issues, an awareness of the role of cultural diversity in the lives of clients and therapists, and a commitment to cultural humility will best prepare music therapists to provide women the support they need, when and as they need it, for their recovery and ultimate empowerment.

The current scope of the practice of music therapy with women survivors of violence has been explored, identifying a diverse array of methods used involving receptive, improvisational, re-creative, and compositional music therapy. A newly-developed practice of Feminist Music Therapy has been outlined with its particular use of music therapy methods infused with an understanding of the importance of the sociopolitical. There is relatively small, but gradually increasing amount of available research which documents the effectiveness of music therapy methods used in this area of music therapy practice—documenting their effectiveness as they have been traditionally used and as they have been adapted more recently within Feminist Music Therapy. An examination of these music therapy methods, supported by the research, has also identified the importance of group work, particularly effective in breaking the isolation so often experienced by women survivors of violence.

While there is a need for further research and literature, a strong and vibrant scope of clinical practice currently exists in this emergent area. Underlying this is an understanding of the power of music to transform lives, that in the hands of a well-informed, well-prepared, well-trained, and culturally-sensitive music therapist can be used to effectively empower women survivors of violence.

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Resources

APA Resources on Cultural Competence/Humility

Guidelines for Psychological Practice with Girls and Women:
<http://www.apa.org/about/division/girlsandwomen.pdf>

Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients:
<http://www.apa.org/pi/lgbc/guidelines.html>

Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists: <http://www.apa.org/pi/multiculturalguidelines/formats.html>

Guidelines for psychotherapy with PTSD: Information for ordering at
<http://www.istss.org>

Intimate Partner Abuse and Relationship Violence: <http://www.apa.org/pi/iparv.pdf>

Women's Music Resources

Lady Slipper Music: <http://www.ladyslipper.org/>